Appendix 1
Instructions for Submitting Claims and Reporting for Obstetric Care Services

Rural health clinic (RHC) providers may choose to submit claims for obstetric (OB) services using either the separate OB component procedure codes as they are performed or the appropriate global OB procedure code with the date of delivery as the date of service (DOS).

Note: Only antepartum and postpartum care services are considered RHC services (i.e., they can be included on the annual and quarterly Medicaid RHC cost reports). Deliveries, while they may be covered by Medicaid, are not RHC services, and, therefore, they cannot be included on the cost report.

Wisconsin Medicaid will not reimburse individual antepartum care or postpartum care codes if a provider also submits a claim for global OB care codes for the same recipient during the same pregnancy or delivery.

Separate Obstetric Care Components

Providers should use the following guidelines when submitting claims for separate OB components and reporting them on the Medicaid RHC cost report.

Antepartum Care

Providers should refer to the table that follows as a guide for submitting claims for a specific number of antepartum care visits. Providers should provide all antepartum care visits before submitting a claim to Wisconsin Medicaid.

Providers should use local procedure codes W6000 — "antepartum care; initial visit" — and W6001 — "antepartum care; two or three visits" — when submitting claims for the first through third antepartum care visits with a provider or provider group. For example, if a total of two to three antepartum care visits is performed, the provider should indicate procedure code W6000 and a quantity of "1.0" for the first DOS. For the second and third visits, the provider should indicate procedure code W6001 and a quantity of "1.0" or "2.0," as indicated in the table to the right. The date of the last antepartum care visit is the DOS.

Note: Do not use evaluation and management procedure codes when submitting claims for the first three antepartum care visits. Use of these codes may result in improper reimbursement.

Similarly, for *Current Procedural Terminology* (CPT) codes 59425 — "antepartum care only; 4-6 visits" — and 59426 — "antepartum care only; 7 or more visits" — the provider should indicate the date of the last antepartum care visit as the DOS. The quantity indicated for these two codes may not exceed "1.0."

Occasionally, a provider may be unsure of whether a recipient has had previous antepartum care visits with another provider. If the recipient is unable to provide this information, the provider should assume the first time he or she sees the recipient is the first antepartum visit.

Note: Reimbursement for procedure codes W6000, W6001, 59425, and 59426 is limited to once per pregnancy, per recipient, per billing provider. A telephone call between patients and providers does not qualify as an antepartum visit.

Antepartum Care Claims Submission Guide

Total Visit(s)	Procedure Code*	Description	Quantity
1	W6000	Antepartum care; initial visit	1.0
2	W6000	Antepartum care; initial visit	1.0
	W6001	Antepartum care; two or three visits	1.0
3	W6000	Antepartum care; initial visit	1.0
	W6001	Antepartum care; two or three visits	2.0
4-6	59425	Antepartum care only; 4-6 visits	1.0
7+	59426	7 or more visits	1.0

*Claims for these codes should be submitted with the following types of service (TOS):

- Physicians, physician assistants, and nurse practitioners use TOS "2."
- Assistant surgeons during delivery use TOS "8."
- Nurse midwives use TOS "9."

Postpartum Care

Postpartum care includes all routine management and care of the postpartum patient including exploration of the uterus, episiotomy and repair, repair of obstetrical lacerations and placement of hemostatic packs or agents. These are part of both the post-delivery and post-hospital office visits, both of which must occur in order to receive reimbursement for postpartum care or global obstetric care.

Wisconsin Medicaid reimbursement for postpartum care includes hospital *and* office visits following vaginal or cesarean delivery. In accordance with the standards of the American College of Obstetricians and Gynecologists, postpartum care includes *both* the routine post-delivery hospital care *and* an outpatient/office visit. Post-delivery hospital care alone is included in the reimbursement for delivery. When submitting claims for postpartum care, the DOS is the date of the post-hospital discharge office visit. To receive reimbursement, the recipient *must* be seen in the office. The length of time between a delivery and the office postpartum visit should be dictated by good medical practice. Wisconsin Medicaid does not dictate an "appropriate" period for postpartum care; however, the industry standard is six to eight weeks following delivery. A telephone call between patients and providers does *not* qualify as a postpartum visit.

Reporting Antepartum Care and Postpartum Care Encounters on the Cost Report

To report encounters when claims for antepartum care and postpartum care only procedure codes have been submitted, include:

- The actual number of encounters.
- 100% of fee-for-service payments received.

Global Obstetric Care

Providers may submit claims using global OB codes. However, the delivery component (although covered by Medicaid) is not an allowable RHC service.

Providers choosing to submit claims for global OB care must perform all of the following:

- A minimum of six antepartum visits.
- Vaginal or cesarean delivery.
- The post-delivery hospital visit and a minimum of one postpartum office visit.

When submitting claims for total OB care, providers should use the single most appropriate CPT OB procedure code and a single charge for the service. Use the date of delivery as the DOS.

All services must be performed to receive reimbursement for global obstetric care. Providers are required to provide all six (or more) antepartum visits, delivery, and the postpartum office visit in order to receive reimbursement for global OB care. If fewer than six antepartum visits have been performed, the provider performing the delivery may submit a claim using the appropriate delivery procedure code and, as appropriate, antepartum and postpartum visit procedure codes.

If the required postpartum office visit does not occur following claims submission for the global delivery, the provider must adjust the claim to reflect antepartum care and delivery if there is no documentation of a postpartum visit in the patient's medical record. (Refer to the section on postpartum care.)

Group Claims Submission for Global Obstetric Care

When several OB providers in the same clinic or medical/surgical group practice perform the delivery and provide antepartum and postpartum care to the same recipient during the period of pregnancy, the clinic may choose to submit a claim using a single procedure code for the service. When submitting the claims, providers should indicate the group Medicaid billing number and identify the primary OB provider as the performing provider.

Reporting Global Obstetric Care Encounters on the Cost Report

To report encounters in the cost report when claims for OB services have been submitted using global OB codes, providers should use the following guidelines.

Report the actual number of antepartum and postpartum visits as encounters. Report the difference between the global OB procedure code reimbursement and the maximum fee for delivery as the amount reimbursed by Wisconsin Medicaid for the antepartum and postpartum care encounters. Refer to the "Global OB Care CPT codes and their Corresponding Delivery CPT Codes" chart below to determine which delivery code to use with the global OB codes.

When reporting encounters associated with a global OB code, use the date of delivery as the DOS.

For a maximum fee schedule, refer to Wisconsin Medicaid's Web site at *www.dhfs.state.wi/medicaid/*.

Global Obstetric (OB) Care *Current Procedural Terminology* (CPT) Codes and their Corresponding Delivery CPT Codes			
Global OB CPT Codes		**Corresponding Delivery CPT Codes**	
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care	59409	Vaginal delivery only (with or without episiotomy and/or forceps)
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care	59514	Cesarean delivery only
59610	Route obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery	59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy, and/or forceps)
59618	Routine obstetric care, following attempted vaginal delivery after previous cesarean delivery	59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery